California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GRAY DAVIS, GOVERNOR

APPLICATION FOR AN EXEMPTION CERTIFICATE

Print or type

Name: Last	First	Middle	Former	TAPE A PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION **NO POLAROID**
*Address of record: Number	Street			
City	State	Zip Code		
Residence Address: (if different from above) Number	Street			
City	State	Zip Code		
Home telephone number ( )	Work telephone number ( )	Date of Birth	Social Security Number **	

Have you previously applied for certification with the board as an exemptee? Yes ☐ No ☐
If "yes," provide the date you applied:_____ Name applied under: _____

Have you previously been **certified** as an exemptee? Yes ☐ No ☐
If "yes," complete the section below and then proceed to section D.

EDUCATION

Name of high school attended _____Location of school (city & state) _____

Graduate from high school Yes ___ Date: _____ GED ___ Date: _____

Name that appears on diploma or GED certificate _____

TRAINING

Name and address	Date of completion/graduation	Degree/Name of course

PHARMACIST EXAM

Are you eligible to take the California pharmacist licensure exam? Yes ☐ No ☐

If "yes," provide the date you applied:_____ Name applied under: _____

DO NOT WRITE BELOW THIS LINE

Live Scan ☐
Photo ☐
Exp Aff ☐
FP Clearance ☐

Training cert ☐
Hours verified_____

Certification No. _____
Date Issued _____

Application fee no. _____
Amount _____
Date Cashiered _____

*Your address of record is public information and will be released to the public upon request, and may be placed on the Internet.

EXEMPTEE EXPERIENCE –List all qualifying experience earned in and out of state performing the tasks of an exemptee. If you have been certified previously as an exemptee in California, provide your exemption certificate number and list experience earned as an exemptee in California. Please attach additional sheets if necessary.

California exemption certificate number _____ Expiration date _____

Dates of employment		Name and address of employer(s)	Total hours experience	Name of person having direct knowledge of your experience
From	To			

EXPERIENCE – List all qualifying experience earned in and out of state.

Dates		Name and address of employer(s)	Total hours experience	Name of person having direct knowledge of your experience
From	To			

California law requires completion of a training program that includes:

- State and federal laws regarding the distribution of dangerous drugs and dangerous devices
- State and federal laws regarding the distribution of controlled drugs
- United States Pharmacopoeia standards for the safe storage and handling of drugs
- Knowledge of quality control systems
- Prescription terminology, abbreviations, dosages and format

You must provide a written explanation for all affirmative answers. Failure to do so may result in this application being deemed incomplete.

1. Do you currently engage, or have you been engaged in the past two years, in the illegal use of controlled substances? Yes ☐ No ☐

   If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **Attach a statement of explanation**.

2. Has disciplinary action ever been taken against your pharmacist license, intern permit or exemption certificate in this state or any other state? **If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes ☐ No ☐

3. Have you ever had an application for a pharmacist license, intern permit or exemption certificate denied in this state or any other state? **If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes ☐ No ☐

4. Have you ever had a pharmacy permit, or any professional or vocational license, certification or registration denied or disciplined by a governmental authority in this state or any other state? **If "yes," provide the name of company, type of permit, type of action, year of action and state.** Yes ☐ No ☐

5. Have you ever been convicted of or pled no contest to a violation of any law of a foreign country, the United States or any state laws or local ordinances? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside under Penal Code sections 1000 or 1203.4. Traffic violations of $500 or less need not be reported. **If "yes," attach an explanation including the type of violation, the date, circumstances, location and the complete penalty received.** Yes ☐ No ☐

6. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, or any other entity licensed in this state or any other state? If yes, provide company name, type of permit, permit number and state where licensed. Yes ☐ No ☐

7. Do you have, or have you had in the last 5 years, any direct or indirect beneficial interest in any other premises licensed by the Board of Pharmacy? Yes ☐ No ☐

8. Have you ever been in violation of any provisions of pharmacy law? Yes ☐ No ☐

9. Are you currently or have you previously been associated in business with any person, partnership, corporation or other entity, or shared a financial or community property interest with any person whose permit or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state by a federal regulatory agency? Yes ☐ No ☐

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

_____ _____

Signature of applicant (in full—no initials) Date signed

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USCA 405(c)(2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code. If you fail to disclose your social security number, your application for license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.